BHSF Form 1-LTC SSI
Issued 2011/01

Long Term Care Application for SSI Recipients

STEP 1 ANSWER THESE QUESTIONS.

1. Have you or your spouse ever had ownership in an annuity or similar investment account? ☐ **Yes** ☐ **No**
2. Have you or your spouse ever given away, sold, or had the name changed on a policy or deed for any item of value such as land, houses, life/burial insurance, vehicles, bank accounts, or cash? ☐ **Yes** ☐ **No**
3. Have you ever created a trust, put any items in a trust, had a trust set up for you, or are you the beneficiary of a trust? ☐ **Yes** ☐ **No**
4. Do you own or are you buying your home? ☐ **Yes** ☐ **No** Value of home $_____
5. Does your spouse wish to apply for Medicaid? ☐ **Yes** ☐ **No**

STEP 2 READ THESE RIGHTS AND RESPONSIBILITIES.

The word "You" in this section applies to the person applying for Long Term Care Medicaid, their legal spouse, or anyone acting on their behalf. If the applicant is under 18 years old, "You" also refers to the parents of the applicant.

WHAT MEDICAID HAS THE RIGHT TO EXPECT OF YOU

CITIZENSHIP AND IMMIGRATION STATUS: You state that everyone who is applying is a U.S. citizen or is in this country legally.

REPORTING THE TRUTH: You agree that the information you give is true and correct. You understand if you purposely give information that is not true OR if you purposely do not tell information that you are supposed to, you may get health benefits that you should not get. If that happens, you can by law be punished for fraud. Also, you may have to pay money back to Medicaid for the bills it paid by mistake.

VERIFICATION OF INFORMATION: You understand that the information you give about yourself will be checked. You agree to help Medicaid check the information you give and to let Medicaid get information it needs from government agencies, employers, medical providers, and others.

SOCIAL SECURITY NUMBERS: You understand Social Security numbers will only be used to get information from other government agencies to make a decision of eligibility for the person(s) applying for Medicaid.

PAYMENT OF MEDICAL CARE BY A THIRD PARTY: You understand by accepting Medicaid, the Department of Health and Hospitals has the right to get money received by you and/or the person(s) applying from other sources like insurance payments or lawsuit settlements for services that Medicaid has paid for you and/or the person(s) applying.

REPORTING CHANGES: You agree to tell Medicaid within 10 days of these changes: 1) if anyone getting Medicaid moves out of state 2) changes in income; 3) changes in mailing or home address; 4) changes in health insurance and premiums; 5) changes in things owned by anyone who gets Medicaid who is disabled or age 65 or older.

ESTATE RECOVERY: You understand that Estate Recovery rules require the Department to recover the cost of certain Medicaid payments from your estate. These costs include the total amount of payments for facility services, waiver services, hospital care, and prescription drugs received at age 55 or older by LTC and/or HCBS recipients. The Department will not make a claim against the estate while you or your legal spouse is still living or if you have a dependent child who is under age 21, blind, or disabled. Collection may not be made if it is not cost effective for the Department to do so, or if your heirs apply for a hardship waiver after your death and the hardship waiver is granted by the Department. A hardship may exist if the estate property is the only source of income for the heirs, if that income is limited, or other extenuating circumstances.

ANNUITIES: You understand that you and your spouse must tell us about any annuity or similar investments. By accepting Medicaid Long Term Care Services you understand that, if you have any ownership interest in any annuity or similar investment account, the State of Louisiana becomes a remainder beneficiary for any annuity purchased on or after February 8, 2006.

WHAT YOU HAVE THE RIGHT TO EXPECT FROM MEDICAID

RIGHT TO A FAIR HEARING: You understand that you can ask for a Fair Hearing if you think any decision made on the case is unfair, incorrect, or made too late.

NO DISCRIMINATION: You understand Medicaid cannot treat you differently because of race, color, sex, age, disability, religion, nationality, or political belief. If you think it has, you can call the U.S. DHHS Regional Office for Civil Rights in Dallas, TX at 1-800-368-1019 or write to Louisiana's Department of Health & Hospitals, Human Resources at P. O. Box 4818 Baton Rouge, LA 70821-4818.

OTHER SERVICES: You understand that information about WIC, KIDMED, and other Medicaid services will be sent to the persons that are eligible for Medicaid.

STEP 3 SIGN BELOW AFTER YOU HAVE READ THESE RIGHTS AND RESPONSIBILITIES.

Applicant or Representative Signs Here:_____ **Date**_____

Applicant's Spouse Signs Here:_____ **Date** _____

If anyone signs with an "X", two witnesses must sign.

_____	_____	_____	_____
Witness #1 Signature	***Date***	***Witness #2 Signature***	***Date***

If you have questions, call the worker who sent this form or 1-888-342-6207.
If you are deaf or hard of hearing and have a TTY text telephone, call 1-800-220-5404.

Case Name: _____ *Case #:* _____